Virginia Department of Behavioral Health & Developmental Services

Referral for Dental Services

Date of Request: _____

Individuals Name: _____ Date of Birth: _____

Person needing dental care

☐ This individual has an intellectual or developmental disability as defined by the VA Code

☐ This individual is in need of Dental Care

Date of their last dental visit: _____

Does the individual have Medicare/Medicaid? ☐ Yes ☐ No

If yes, what Managed Care Organization (MCO) have they selected? _____

Has the individual been able to secure a dental appointment with the MCO plan if applicable? _____

Comments: _____

Legal Guardian/Authorized Representative: _____

Phone Number: _____ Email: _____

Community Service Board Case Manager: _____

Phone Number: _____ Email: _____

Does the individual require any type of sedation for their dental visits? ☐ Yes ☐ No ☐ Unsure

Is this individual a previous resident of any Virginia Training Center? ☐ Yes ☐ No ☐ Unsure

The dental team will review your request to make sure that the individual meets the program criteria for your region of Virginia. We will contact you once that review is complete.

If selected for the dental program, please remember that the individual must be accompanied by someone who knows their medical, dental and behavioral history at all appointments.

Signature: _____ Date: _____

This individual's referral to the DBHDS Dental Program has been: ☐ approved ☐ denied

Referred To: _____

Address: _____

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CLIENT INFORMATION

CLIENT NAME:_____
(FIRST) (MIDDLE) (LAST)

CLIENT ADDRESS:

_____

Number/Street or P.0. Box/ Group Home name

City/Town State Zip Code Phone

BIRTH DATE_____**AGE**:_____ **SEX**: M F (circle)

ID/DD level (circle) Profound Severe Moderate Mild

RESIDENTIAL PROVIDER: Contact person/Caregiver _____

Phone: _____Email:_____

EMERGENCY CONTACT:_____Relationship:_____

Phone:_____Email:_____

MEDICAL DIAGNOSIS:

_____

_____

_____

PRESCRIBED MEDICATIONS:

_____

_____

_____

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ALLERGIES:(please describe reaction)

_____

_____

_____

CAPABILITIES: (CIRCLE THOSE THAT APPLY)

a. Ambulatory: Yes No Use: Wheelchair Walker Other

b. Communication: Non-verbal Gestures Manual Signing Vocalizations Verbal

c. Sensory Impairments: Partially Deaf Deaf Partially Blind Blind

d. Total staff assistance Mostly staff assistance Minimal staff assistance Independent

ADDITIONAL PATIENT CONSIDERATIONS: (include likes, dislikes, previous experiences, concerns)

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Please return these completed forms to Casey Tupea and/or Tamika Clark via fax at (804) 692-0077

or by email to casey.tupea@dbhds.virginia.gov and tamika.clark@dbhds.virginia.gov